have elapsed since the empoyee last returned to work. In any case in which there may be doubt that the symptoms or disability are the result of the injury, or in which it has been more than six months since the last return to work, the designated agency official shall communicate with the Office and request instructions, stating all the pertinent facts. In all other cases, the employee shall communicate with the Office and request such treatment.

[49 FR 18979, May 3, 1984]

§ 10.406 Authority for dental treatment.

All necessary dental treatment, including repairs to natural teeth, false teeth, and other prosthetic dental devices, needed to repair damage or loss caused by an employment related injury shall be obtained at the employee's option from a U.S. Medical Officer or hospital, or from a duly qualified private dentist, a duly qualified physician, or a duly qualified hospital, upon authorization obtained in advance from the Office.

[49 FR 18980, May 3, 1984]

§ 10.407 Medical examinations.

(a) An injured employee shall be required to submit to examination by a U.S. Medical Officer or by a qualified private physician approved by the Office as frequently and at such times and places as in the opinion of the Office may be reasonably necessary. The injured employee may have a duly qualified physician, paid by him or her, present at the time of such examination. For any examination required by the Office, an injured employee shall be paid all expenses incident to such examination which, in the opinion of the Office, are necessary and reasonable, including transportation and actual loss of wages incurred in order to submit to the examination authorized by the Office.

(b) If the employee refuses to submit himself or herself for or in any way obstructs any examination required by the Office pursuant to paragraph (a) of this section, the employee's right to compensation under the Act shall be suspended until such refusal or obstruction ceases. Compensation otherwise paid or payable under the Act and this part for the period of the refusal or obstruction is forfeited and, where already paid, is subject to recovery pursuant to 5 U.S.C. 8129. When notifying an employee of an examination required under paragraph (a) of this section, the Office shall inform the employee of the penalty for refusing or obstructing the examination.

[49 FR 18980, May 3, 1984]

§ 10.408 Medical referee examination.

If there should be a disagreement between the physician making the examination on the part of the United States and the injured employee's physician, the Office shall appoint a third physician, qualified in the appropriate speciality, who shall make an examination. The physician appointed shall be one not previously connected with the case.

§ 10.409 Furnishing of orthopedic and prosthetic appliances, and dental work.

When a job-related injury results in the need for an orthopedic or prosthetic appliance, such as an artificial limb, eye, or denture, as recommended by the duly qualified attending physician, written application for authority to purchase such appliance may be made to the Office. The application must include a statement from the attending physician regarding the need for the appliance, a brief description thereof, and the approximate cost.

[49 FR 18980, May 3, 1984]

§ 10.410 Recording and submission of medical reports.

(a) Medical officers and private physicians and hospitals shall keep adequate records of all cases treated by them under the Act so as to be able to supply the Office with a history of the employee's accident, the exact description, nature, location, and extent of injury, the X-ray findings or other studies, if X-ray examination or other studies have been made, the nature of the treatment rendered, and the degree of impairment arising from the injury.

(b) Form CA–16 provides for the furnishing of the initial medical report. Form CA–20 may also be used for the

initial report and for subsequent report. The medical report Form CA–20a attached to Form CA–8 is to be utilized in instances where continued compensation is claimed on such form. These reports shall be forwarded promptly to the Office. In cases of disabling traumatic injuries Form CA–17 shall be used to obtain interim reports concerning the employee's duty status. These reports are necessary to support continuation of pay up to 45 days.

(c) Detailed supplementary reports in narrative form shall be made by the physician at approximately monthly intervals in all cases of serious injury or disease, especially injuries of the head and back, and including all cases requiring hospital treatment or prolonged care. The supplementary report shall show the date the employee was first examined or treated, the patient's complaint, the condition found on examination, the diagnosis and medical opinion as to any relationship between the impairment and the injury or employment factors alleged, report as to any other impairments found not due to injury, the treatment given or recommended for the injury alleged, the extent of impairment affecting the employment as a result of the injury, the actual degree of loss of active or passive motion of an injured member, the amount of atrophy or deformity in a member, the decrease, if any, in strength, the disturbance of sensation, the prognosis for recovery, and all other material findings. If the services of a specialist are required in the examination or treatment of the employee, a report of his findings upon examination, his diagnosis, his opinion as to the relationship between the impairment and the injury and/or conditions of employment, the medical rationale for his opinion, the treatment recommended by him, a statement of the extent of impairment as a result of the injury or employment and the prognosis shall be forwarded to the Office for consideration in conjunction with other reports. The requirement of this section or of any section in this part with respect to the form of medical, dental, hospital or other reports may be waived by the Office.

[40 FR 6877, Feb. 14, 1975, as amended at 49 FR 18980, May 3, 1984]

§ 10.411 Submission of bills for medical services, appliances and supplies; limitation on payment for services.

(a)(1) All charges for medical and surgical treatment, appliances or supplies furnished to injured employees, except for treatment and supplies provided by hospitals, pharmacies and nursing homes, shall be supported by medical evidence as provided in § 10.410, itemized by the physician or provider on the American Medical Association standard ''Health Insurance Claim Form,'' OWCP 1500a ''Instructions for Completing Health Insurance Claim Form,'' and shall be forwarded promptly to the Office for consideration. The provider of such service shall identify each service performed, using the Health Care Financing Administration Common Procedure Coding System (HCPCS as periodically revised), with brief narrative description or, where no code is applicable, a detailed description of services performed. The provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the ''International Classification of Disease, 9th Edition, Clinical Modification'' (ICD–9–CM). A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the work-related condition is necessary for more than 30 days.

(2) Charges for medical and surgical treatment provided by hospitals shall be supported by medical evidence as provided in § 10.410. Such charges shall be submitted by the provider on the Uniform Bill (UB–82). The provider shall identify each outpatient radiology service (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services), outpatient pathology service (including automated, multichannel tests, panels, urinalysis, chemistry and toxicology, hematology, microbiology, immunology and anatomic pathology), and physical therapy service performed, using HCPCS/CPT codes with a brief narrative description. The charge for each individual service, or the total charge for all identical services should also appear in the UB–82. Other outpatient hospital services for which